

**PHYSICIAN'S HEALTH APPRAISAL
CHAPPAQUA CENTRAL SCHOOL DISTRICT
Horace Greeley High School**

Name: _____ Date: _____
 Address: _____ Grade entering (or as of 9/1/) _____
 Telephone # _____ Date of Birth _____
 Physician's Name _____ Physician's Telephone # _____

List the specific sports in which your child will be participating for each season:

Fall _____ Winter _____ Spring _____

I. Past Medical History (to be completed by physician or parent/guardian)

	Yes	No	Dates/details
Hospitalizations			
Operations/Surgery			
Daily Medications			
Allergies			
Significant Illnesses and/or Injuries			
Current conditions being monitored by a physician			

II. Additional History Required for Sports Participation (to be completed by parent/guardian)

	Yes	No	Dates/details
Ever denied full athletic participation?			
Absence of a paired organ			
Anemia			
Asthma/respiratory disorder			
Concussion (Number _____)			
Frequent or Severe Headaches			
Fainting/passing out			
Heat exhaustion/heat stroke			
Heart disease- student			
Heart disease- family			
Hypertension			
Mononucleosis			
Seizures/epilepsy			
Describe any major musculo-skeletal injury or problem that occurred in the last 3 years			

III. Parent/Guardian Attestation (For All Sports Participation)

I declare that the above information is an accurate and true reflection of my child's condition.

Parent/guardian Signature _____ Date _____

IV. Parent/Guardian Permission (For In-School Sports Physicals Only)

I give permission for the Chappaqua District Medical Team to perform the Pre-sports Evaluation.

Parent/Guardian Signature _____ Date _____

V. Physical Examination

Height: _____ Weight: _____

Required for Sports Clearance: Pulse _____ BP _____

	Normal	Other (Specify)
Skin		
Lymph Nodes		
HEENT		
Lungs		
Heart		
Abdomen		
Genitourinary		
Extremities		
Orthopedic		
Scoliosis		
Neurologic		

VI. Orthopedic Examination (required for sports)

	Normal	Other (Specify)
Neck		
Back		
Shoulder		
Upper extremities		
Lower extremities		
Hamstrings. Finger-tip distance from floor: _____ inches		

VII. Testing, Laboratory and Immunizations

Vision: L _____ R _____ Hearing: L _____ R _____

Laboratory: _____ Last Tetanus _____

VIII. Summary

Emotional Status: ? Well ? Other. Specify: _____

Physical Assessment: ? Well ? Other. Specify: _____

Physical Education: ? Permitted ? Restrictions. Specify: _____

Sports participation: ? Permitted ? Restrictions. Specify: _____

IX. Examining Physician

Signature: _____ Stamp: _____

Phone: _____ Date of Exam: _____

X. For Sports Clearance Only

Chappaqua Central Schools Medical Director Review _____ Date _____